from renal calculus, having been diagnosed, the kidney was exposed by lumbar incision. On dividing the kidney tissue an abscess was opened which the writer believes to have been formed in a Malpighian pyramid, the outlet of which was closed by the stone lodged in a calyx. Further incision exposed a calcium oxalate stone, weighing 30 grains and shaped somewhat like a cocked hat; it was easily extracted, the wound irrigated with a 1-4000 sublimate solution, a large drainage tube inserted into the pelvis of the kidney, and an iodoform dressing applied. The patient made a good recovery and there was apparently no disturbance of gestation.—*Med. News*, April 16, 1887.

VIII. Digital Exploration of the Kidneys. By WILLIAM T. BELFIELD, M.D., (Chicago). The author calls attention to the fact that the greatest obstacle to the early surgical treatment of renal lesions has been faulty diagnosis, and summarizes as follows: (1) Surgical affections of the kidney are frequently long masked by symptoms of cystitis, etc.; differential diagnosis may be practically impossible without palpation of the kidney. (2) Digital exploration of the kidney through a lumbar incision is, with proper precautions, almost free from danger, comparing favorably with perineal exploration of the bladder. (3) This operation, performed at an early period, may arrest a morbid process which would otherwise require nephrectomy; even if it secures no other immediate results than accurate diagnosis, it diminishes the danger from subsequent nephrectomy. (4) Before undertaking to incise the pelvis, the functional activity of the other kidney should be demonstrated by examination of its secretion.—*N. Y. Med. Rec.*, May 14, 1887.

IX. Stab Wound of the Kidney; Recovery. By FRANK HARTLEY, M.D., (New York). A man, æt. 25, was stabbed with a large sailor's knife, receiving a wound an inch and a half long on the right side, between the ninth and tenth ribs, midway between the mammary and axillary lines, from which blood flowed continuously. He was suffering from severe shock, his pulse was rapid and feeble, and the surface was cold, although he was conscious; the wound and sur-

rounding parts were immediately disinfected with 1-1000 sublimate solution and, four hours later, his condition having somewhat improved, he was anæsthetized and the wound enlarged sufficiently to admit the hand, by an incision downward and slightly forward; the ascending part of the transverse colon could now be seen. The hand was passed through the wound and entered the peritoneal cavity, where it distinctly felt the liver, the gall-bladder and the transverse and ascending colon, all uninjured. On continued examination with the hand, a cut was discovered in the right kidney about two and a half inches long, running from its outer to its inner border and passing completely through its substance; three fingers were passed into this wound and the calices were distinctly felt along the inner border of the kidney, one of them appearing to be completely severed. On account of the profuse hæmorrhage, the severe shock and the opening into the peritoneal cavity, it was thought advisable not to perform nephrotomy, which would have required much time, increased the already existing shock, and doubtless favored a fatal termination. It was therefore considered more prudent to control the hæmorrhage, provide a free exit for the subsequent discharge of urine, and shut off the peritoneal cavity from infection; accordingly, the wound was carefully washed out with a warm boro-salicylic solution; two drainage tubes were inserted at the upper and lower angles of the wound, a third drainage tube being passed directly into the kidney to its inner border, and all were fastened to the skin with catgut sutures. The patient was then placed upon his side and the wound again thoroughly cleansed with the same solution. The peritoneal cavity was closed off from the retroperitoneal cavity as completely as possible by packing iodoform gauze in the wound, allowing the ends of the gauze to hang outside; when this was thought to be certainly accomplished, the wound was itself packed in the same way down to the kidney, and was partially closed with catgut sutures, and an iodoform and sublimate dressing applied over all. The patient did well and was discharged from the hospital six months later with the wound entirely healed except a sinus leading to the kidney, through which a small amount of urine escaped. A month after this he had completely recovered.—*N. Y. Clinical Society*, March 25, 1887.

JAMES E. PILCHER (U. S. Army).